STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain the doors protecting the corridors. The findings include: 1. Observation during the fire drill on 7/10/10 at 12:35 p.m. revealed the corridor's fire door located next to room 132 did not latch to the door frame. National Fire Protection Association (NFPA) 80, 15-1.2 2. Observation during the fire drill on 7/12/10 at 12:40 p.m. revealed the secured unit's living room	K 018	K 018 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all corridor doors close and latch as Designed to maintain compliance at all Times to include: The Director of Maintenance and adjusted the fire door next to room 132 to properly latch on 7/23/10. The door now latches to the door frame. 7/23/10 The Director of Maintenance and Maintenance Assistant adjusted the Secured unit living room door to Eliminate sticking to the door frame on 7/26/10. The door no longer sticks to the door frame. 7/26/10 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Corridor and egress doors on 7/28/10 and all doors latch to door frames as required. 7/28/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katrina Morris CO	Executive Director	7/29/10

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 018	Continued From page 1 door was sticking to the door frame. NFPA 80,15-1.2 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 018	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Facility corridor and egress doors monthly Per this facilities Preventative Maintenance Program to ensure functionality and code Compliance and present the audit findings to the QA Committee. Any fire doors found to be non compliant will be corrected.	7/28/10
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to post 2 exit signs in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 11:35 a.m. revealed there were no illuminated exit signs posted above the corridor doors next to rooms 100 and 106. National Fire Protection Association (NFPA) 101, 7.10.1.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 022	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Door Audit and Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A, Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

ID FIX G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
018	Continued From page 1 door was sticking to the door frame. NFPA 80,15-1.2 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 018		
022 S=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to post 2 exit signs in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 11:35 a.m. revealed there were no illuminated exit signs posted above the corridor doors next to rooms 100 and 106. National Fire Protection Association (NFPA) 101, 7.10.1.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 022	K 022 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all exit doors maintain proper signage to maintain compliance at all times to include: The Director of Maintenance posted An illuminated exit sign above the corridor Doors next to rooms 100 and 106 on 8/2/10. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed similar Openings for the need for signage on 7/28/10, and appropriate areas have illuminated signage as required.	8/2/10 7/28/10
25	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 018	Continued From page 1 door was sticking to the door frame. NFPA 80,15-1.2 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Facility openings monthly and document findings In the Preventative Maintenance Program logs to ensure functionality and code compliance and present the audit findings to the QA Committee. Any areas found to be non compliant will be corrected.	7/28/10
K 022	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to post 2 exit signs in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 11:35 a.m. revealed there were no illuminated exit signs posted above the corridor doors next to rooms 100 and 106. National Fire Protection Association (NFPA) 101, 7.10.1.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Facility Signage Audit and Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A, Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10
K 025	NFPA 101 LIFE SAFETY CODE STANDARD		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
:E CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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Continued From page 1 door was sticking to the door frame. NFPA 80,15-1.2 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 018		
NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to each exit is not readily apparent to the occupants. 7.10.1.4	K 022		
This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to post 2 exit signs in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 1:35 a.m. revealed there were no illuminated exit signs posted above the corridor doors next to rooms 100 and 106. National Fire Protection Association (NFPA) 101, 7.10.1.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.		K 025 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all fire/smoke cubicles remain Within compliance at all times to include: A Contract Vendor repaired the penetrations In the 2 smoke barriers located in the attic Above room 116 and the D Corridor On 8/2/10.	8/2/10
NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
E CARE CENTER OF CROSSVILLE	89 JUSTICE ST CROSSVILLE, TN 38555

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025 S=F	Continued From page 2 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain 2 of the 2 smoke barriers located in the attic. The findings include: Observation on 7/12/10 at 10:00 a.m. revealed penetrations in the 2 smoke barriers located the attic above room 116 and the D corridor. National Fire Protection Association (NFPA) 101, 8.2.4.4.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 025	2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Smoke barriers on 7/28/10 and all Are compliant. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Smoke barriers for penetrations monthly Per this facilities Preventative Maintenance Program to ensure functionality and code Compliance and present the audit findings to the QA Committee. Any smoke barriers found to be non compliant will be corrected.	7/28/10 7/28/10
038 S=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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K 025 SS=F	Continued From page 2 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain 2 of the 2 smoke barriers located in the attic. The findings include: Observation on 7/12/10 at 10:00 a.m. revealed penetrations in the 2 smoke barriers located the attic above room 116 and the D corridor. National Fire Protection Association (NFPA) 101, 8.2.4.4.2 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 025	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Smoke Barrier Penetration Audit to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A., Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1	K 038		

ENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the exit access in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 11:40 a.m. revealed the doors installed in the corridor next to room 106 did not open toward the direction of travel (egress access). National Fire Protection Association (NFPA) 101, 7.2.1.4.3 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 038	K 038 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all exits remain accessible and Discharge to a safe refuge at all times to include: A Contract Vendor installed and adjusted doors in the corridor next to room 106 to open toward the direction of travel (egress access) on 8/2/10. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Corridor and egress doors on 7/28/10 and all doors open toward the direction of travel (egress access) as required. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Facility corridor and egress doors monthly Per this facilities Preventative Maintenance Program to ensure the doors open toward The direction of travel (egress access) And present the audit findings to the QA Committee. Any doors found to be non compliant will be corrected.	8/2/10 7/28/10 7/28/10
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined the facility failed to maintain the fire alarm system.	K 052		

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the exit access in the secured wing. The findings include: Observation of the secure wing on 7/12/10 at 11:40 a.m. revealed the doors installed in the corridor next to room 106 did not open toward the direction of travel (egress access). National Fire Protection Association (NFPA) 101, 7.2.1.4.3 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 038	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Corridor and Door Audit and Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A, Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined the facility failed to maintain the fire alarm system.	K 052		

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K 052	Continued From page 4 The findings include: Observation and testing of the main fire alarm panel located in the main lobby on 7/12/10 at 11:50 a.m. revealed that when phone lines #1 or #2 were disconnected from the panel. There were no visual/audible trouble signals at one of the two nurses' station. Interview with the Director Of Maintenance on 7/12/10 at 11:55 a.m. revealed that main fire alarm panel was not monitored by the staff during the night. The trouble signal(s) shall be located in an area where it is likely to be heard. National Fire Protection Association (NFPA) 72, 1-5.4.6 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 052	K 052 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That fire alarm systems are installed, tested And maintained in accordance with NFPA 70 And 72 to maintain compliance at all times to include: A Contract Vendor installed a visual/audible trouble alarm that is monitored 24/7 By facility staff on 8/2/10.	8/2/10
			2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Trouble alarms on 7/28/10 and all are visual/audible for staff to hear as required.	7/28/10
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system. The findings include: 1. Observation on 7/12/10 at 9:50 a.m. revealed the entrance porch sprinklers (4) were corroded. The sprinklers must be replaced not cleaned.	K 062	3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Trouble alarms monthly Per this facilities Preventative Maintenance Program to ensure they are visual/audible for Staff to hear and present the audit findings to the QA Committee. Any trouble alarms found to be non compliant will be corrected.	7/28/10

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K 052	Continued From page 4 The findings include: Observation and testing of the main fire alarm panel located in the main lobby on 7/12/10 at 11:50 a.m. revealed that when phone lines #1 or #2 were disconnected from the panel. There were no visual/audible trouble signals at one of the two nurses' station. Interview with the Director Of Maintenance on 7/12/10 at 11:55 a.m. revealed that main fire alarm panel was not monitored by the staff during the night. The trouble signal(s) shall be located in an area where it is likely to be heard. National Fire Protection Association (NFPA) 72, 1-5.4.6 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 052	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Trouble Alarm Audit and Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system. The findings include: 1. Observation on 7/12/10 at 9:50 a.m. revealed the entrance porch sprinklers (4) were corroded. The sprinklers must be replaced not cleaned.	K 062	Consisting of a C.N.A, Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10

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	445167	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system. The findings include: 1. Observation on 7/12/10 at 9:50 a.m. revealed the entrance porch sprinklers (4) were corroded. The sprinklers must be replaced not cleaned.	K 062	K 062 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That the sprinkler system is maintained And inspected to ensure compliance at All times to include: A Contract Vendor replaced the corroded Sprinkler heads (4) on the entrance porch On 8/2/10. The Director Maintenance and Maintenance Assistant removed lint and blown insulation On the sprinklers in the attic above West B and D corridors on 7/23/10.	8/2/10 7/23/10

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K 062	Continued From page 5 National Fire Protection Association (NFPA) 25, 2-2.1 2. Observation on 7/12/10 at 10:05 a.m. revealed the sprinklers located in the attic above the West B and D corridors had lint and blow insolation on the sprinklers. NFPA 25, 2-2.1.1 3. Observation on 7/12/10 at 10:27 a.m. revealed corroded sprinklers in the exit canopies located in the Memory care unit, A corridor (West), and next to room 162 NFPA 25, 2-2.1.1 4. Observation of the sprinkler located in the corridor next to room 138 on 7/12/10 at 12:26 p.m. revealed the sprinkler's deflector was not parallel to the ceiling. NFPA 13, 5.5.4.2 Records review on 7/1210 at 1:15 p.m. revealed the facility was unable to provide documentation that the sprinkler system's gages were replaced or tested every 5 years. NFPA 25, 2-2.1 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 062	A Contract Vendor replaced the corroded Sprinkler heads in the exit canopies located In the Memory care unit, A corridor (West), And next to room 162 on 8/2/10. The Director of Maintenance moved the Sprinkler deflector parallel to the ceiling In the corridor next to room 138 on 7/23/10. A Contract Vendor/Licensed Contractor Tested the facility sprinkler system gages As required every 5 years on 7/21/10. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Sprinkler heads on 7/23/10 and all are Lint free, insulation free, corrosion free And have been inspected by a Licensed Contract as required. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit Facility sprinkler heads monthly Per this facilities Preventative Maintenance Program to ensure functionality and code Compliance and present the audit findings to the QA Committee. Any fire doors found to be non compliant will be corrected.	8/2/10 8/2/10 7/21/10 7/23/10 7/28/10
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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K 062	Continued From page 5 National Fire Protection Association (NFPA) 25, 2-2.1 2. Observation on 7/12/10 at 10:05 a.m. revealed the sprinklers located in the attic above the West B and D corridors had lint and blow insolation on the sprinklers. NFPA 25, 2-2.1.1 3. Observation on 7/12/10 at 10:27 a.m. revealed corroded sprinklers in the exit canopies located in the Memory care unit, A corridor (West), and next to room 162 NFPA 25, 2-2.1.1 4. Observation of the sprinkler located in the corridor next to room 138 on 7/12/10 at 12:26 p.m. revealed the sprinkler's deflector was not parallel to the ceiling. NFPA 13, 5.5.4.2 Records review on 7/1210 at 1:15 p.m. revealed the facility was unable to provide documentation that the sprinkler system's gages were replaced or tested every 5 years. NFPA 25, 2-2.1 These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 062	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the Sprinkler Head Audit and Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A, Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate, RN Staff Development Coordinator, and Director of Nursing will review the findings and Make recommendations and develop Plans of action if any areas are noted to Be non-compliant.	7/28/10
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067		

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K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067	K 067 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all HVAC systems comply with NFPA 90A at all times to include: A Contract/Licensed Vendor completed an Inspection of the facilities HVAC fire dampers as required every four years on 7/15/10.	7/15/10

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K 067	Continued From page 6 Based on record review it was determined the facility failed to maintain the heating, ventilating, and air conditioning (HVAC) fire dampers. The findings include: Records review on 7/12/10 at 1:20 p.m. revealed the facility was unable to provide documentation that the HVAC fire dampers were inspected every 4 years. NFPA 90A, 3-4.7 This finding was acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 067	2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance ensured on 7/28/10 that the next 4 year HVAC fire Damper inspection is scheduled to occur.	7/28/10
			3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance maintain System inspections and services monthly Per this facilities Preventative Maintenance Program to ensure functionality and code Compliance and present the audit findings to the QA Committee. Any system issues or inspections due will be resolved.	7/28/10
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Penetrations and Miscellaneous Openings in Fire Barriers such as Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. Based on observations it was determined the	K 130	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The HVAC inspection, system service records And Preventative Maintenance Logs to the Quality Assurance Committee and Safety Committee Monthly for three consecutive months. The Quality Assurance Committee consisting of The Executive Director, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Staff Development Coordinator, Director of Medical Records, Director of Environmental Services; Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director Of Marketing; and the Safety Committee Consisting of a C.N.A. Activity Assistant, Business Office Associate, Executive Director, Maintenance Director, Dietary Associate,	7/28/10

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K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Penetrations and Miscellaneous Openings in Fire Barriers such as Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. Based on observations it was determined the	K 130	K 130 1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? It is the practice of this facility to assure That all miscellaneous life safety items are In compliance to include: A Contract Vendor repaired the penetrations In the 2 smoke barriers located in the attic Above room 116 and the D Corridor On 8/2/10. The Director of Maintenance and Maintenance Assistant repaired the Penetrations in the ceiling around The bathroom located in room 163; Rooms 112, 136, 151, and 163; and Above the East storage room on 7/23/10.	8/2/10 7/23/10

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TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 130	Continued From page 7 facility failed to the fire barriers. The findings include: 1. Observation on 7/12/10 at 10:00 a.m. revealed penetrations in the fire barrier located in the attic above room 116 and above the D corridor. National Fire Protection Association (NFPA) 101, 8.2.3.2.4.2 2. Observations on 7/12/10 at 10:20 a.m. revealed penetrations in the ceilings around the following sprinklers: 1. Bathroom located in room 163. 2. Rooms 112, 136, 151, and 153. 3. East storage room. These findings were acknowledged by the Administrator and verified by the Director Of Maintenance at the exit interview on 7/12/10.	K 130	2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance and Maintenance Assistant reviewed facility Smoke barriers and ceilings on 7/28/10 and all are compliant. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will audit The smoke barriers and ceilings monthly For penetrations per this facilities Preventative Maintenance Program to ensure functionality and code Compliance and present the audit findings to the QA Committee. Any smoke barriers or ceilings that are found to be non compliant will be corrected.	7/28/10 7/28/10

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